Chapter Two

Overview of the North Carolina Medicaid Program

Chapter Overview

Introduction

This chapter gives basic information on the establishment and administration of the North Carolina Medicaid Program. A general explanation of the client eligibility process is intended to help providers understand how eligibility is established and verified.

In This Chapter

This chapter contains:

The Medicaid Program

What is Medicaid?

Title XIX of the Social Security Act (Medicaid) is a program of medical assistance for certain medically needy and low-income individuals and families who meet the categorical requirements of federal and state laws. North Carolina implemented the Medicaid program in January 1970. The federal Health Care Financing Administration (HCFA) regulates and oversees state Medicaid programs. An agency of the North Carolina Department of Health and Human Services (DHHS), the Division of Medical Assistance (DMA) administers North Carolina's program. DMA contracts with a fiscal agent to process Medicaid claims for payment and to perform other administrative tasks.

Funding

The Medicaid program is funded from federal, state, and county taxes.

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The Medicaid Program, continued

How the Medicaid Program Works

Medicaid operates as a provider payment program. Eligible families and individuals are issued a Medicaid identification card each month. The ID card is proof of eligibility and has printed codes indicating special coverages, third party insurance, copayments for some services and prior approval requirements for certain coverages. Program eligibles receive medical care from providers enrolled in the program who then bill Medicaid for their services.

Who Works With Medicaid

Although DMA oversees and administers the North Carolina Medicaid Program, the participation of providers, organizations, other state agencies and divisions within the DHHS, and federal agencies contribute to the functioning of the program. Some who contribute:

- the health care professionals and institutions who provide care for Medicaid recipients
- the Social Security Administration, which takes applications and determines eligibility for Supplemental Security Income (SSI). Recipients of SSI automatically qualify for Medicaid
- county departments of social services, following state-issued policies, accept Medicaid applications and determine Medicaid eligibility for individuals not applying or receiving SSI. This may include SSI recipients for periods of time prior to the beginning of SSI eligibility
- Electronic Data Systems (EDS), under contract with DMA, processes Medicaid claims and performs a variety of other administrative tasks, including prior approval for some services, and provider education and problem-solving

Covered Services

North Carolina Medicaid provides a variety of programs and services for eligible recipients and special populations.

Medicaid Managed Care Programs

North Carolina Medicaid offers the following managed care programs: Carolina ACCESS, ACCESS II, and HMO Risk Contracting. Under the HMO Risk Contracting Program, ambulance services are an in-plan benefit for HMO participants. Therefore, payment for these services must be sought from the HMO. Information on the participant's Medicaid card identifies HMO enrollees and provides the HMO's name, address, and telephone number. HMO verification may also be verified through the Voice Inquiry System or through Electronic Data Interchange vendors. See Appendix B for telephone numbers.

Medicaid Eligibility

How Eligibility Is Determined

The county Departments of Social Services (DSS) determine Medicaid eligibility for most recipients. Applicants for Medicaid must meet a financial means test and qualify under one of the categories prescribed by federal and state laws. In addition, individuals or families must:

1. be residents of North Carolina
2. be U S citizens or lawfully qualified aliens
3. apply for all benefits for which they are entitled
4. assign their rights for third party benefits to the state
5. meet the financial need (income/assets) requirements for the assistance category

Eligible Categories

The following groups of individuals may be eligible for Medicaid:

- individuals receiving cash assistance under Work First (formerly AFDC)
- individuals receiving State/County Special Assistance
- individuals receiving Supplemental Aid to the Blind
- individuals receiving refugee cash assistance
- children receiving foster care or adoption assistance under Title IV-E of the Social Security Act
- other individuals who are age 65 or above, blind, disabled, pregnant, under age 21, caretakers of children under age 19, or Medicare Part A beneficiaries

Aged, blind, and disabled individuals who receive Supplemental Security Income (SSI) are automatically entitled to North Carolina Medicaid benefits and are not required to make a separate Medicaid application at the county DSS office. SSI eligibility is determined by the Social Security Administration. If a SSI recipient needs Medicaid coverage prior to the effective date of his SSI coverage, he may apply for this coverage at the DSS office in his county of residence.

Medicare Part B Buy-In

Eligible Medicaid recipients **may qualify** for Medicare Part B (physician services) coverage. Through a buy-in program, Medicaid pays the monthly premium for this coverage. To be eligible for Medicare Buy-In, a recipient must first be eligible for Supplemental Medical Insurance (SMI). The following qualify for SMI:

- people age 65 and over who have Medicare Part A
- all other people age 65 or over who are U. S. residents and either citizens or lawfully qualified aliens admitted for permanent residence, who have resided in the U.S. continuously during the five years immediately preceding the month they apply for enrollment
- people under age 65 who are eligible for Medicare Part A because they have been entitled to monthly Social Security benefits under Title II or Railroad disability benefits for 24 months or more
- people under age 65 who have been diagnosed with chronic renal disease and have received kidney dialysis for three months

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Medicaid Eligibility, continued

Refusal to Apply for Medicare Benefits

With the exception of qualified aliens who have not lived in the United States for five consecutive years, all Medicaid recipients age 65 or older are required to apply for Medicare coverage. If a Medicaid recipient is entitled to Medicare benefits, but refuses to apply for and accept benefits, he will be responsible for payment of claims that would have been covered by Medicare.

Disclosure of Medicare Information

The U.S. Supreme Court has ruled that disclosure by the Social Security Administration of an individual's Medicare information, including Medicare number, is prohibited without prior written consent of the beneficiary or by someone who may consent for him. Providers are reminded to ask at the time a service is provided for the patient's Medicare card for the purpose of filing Medicare/Medicaid claims. Medicare A and B coverage is indicated on the MID card in the insurance data block.

When Medicaid Coverage Begins

A recipient's Medicaid eligibility generally begins on the first day of the month in which benefit application is made, if all financial and categorical conditions for eligibility are met. An exception to this rule is eligibility for a Medicare Qualified Beneficiaries (MQB). The beginning date for MQB is the month after the county DSS establishes the person as eligible. Eligibility is most often established for periods of six or twelve months, depending on the recipient's assistance category. The individual must supply information about his/her family's financial circumstances and household composition to be re-enrolled for continued eligibility.

Exception: If the person is required to spend from income to qualify, eligibility begins on the day that his income has been reduced by incurred medical costs to the Medicaid income level. See Medicaid Deductible block on page 2-5.

Retroactive Eligibility

Retroactive coverage for covered services may be approved for up to three months prior to the month of the application if the applicant meets all eligibility conditions in the retroactive period and has unpaid medical bills for any one of the three months prior to application. Providers may choose to accept or decline retroactive eligibility. If a provider accepts retroactive eligibility, all payments made by the recipient must be reimbursed to the recipient.

Retroactive Eligibility and Overrides

In some cases, an application for Medicaid benefits is initially denied but is later reopened and approved due to the reversal of a disability denial, a state appeal, or a court decision. Some of these appeals and reversals are not final for many months. In cases where retroactive eligibility is approved so late that providers have less than 60 days remaining in which to file or if the time limit for claims filing has passed, the county DSS must request an override of the claims filing time limit from DMA. DMA provides written notice to recipients and to the county DSS when time limit overrides are approved. These notices also tell the recipient to notify their providers of retroactive approval.

If a recipient receives notice of override approval, he must immediately inform providers of this. If he fails to do so, the provider may hold the recipient financially liable for the services provided.

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Medicaid Eligibility, continued

Medicaid Deductible

Medicaid income levels for North Carolina Medicaid recipients are set by the North Carolina General Assembly and are based on family size.

A Medicaid deductible is similar to a private insurance deductible. It is the amount of medical expenses for which a patient is responsible before Medicaid will pay for covered services.

Example: A man applies for Medicaid on July 15th. The six-month eligibility period is July through December. His income exceeds the income limit by $300 per month; therefore, the deductible amount for the six-month eligibility period is $1,800 (6 × $300). On the date that his medical expenses for the period total $1,800, he will be approved for Medicaid coverage for that date through the end of the eligibility period.

Medicaid Deductible Exclusions

The following Medicaid recipients do not have to meet the Medicaid deductible requirement:

- those who receive cash payments to meet basic cost of living
- infants to age one
- children age one to 19 who qualify under federal poverty income standards
- pregnant women
- Medicare Qualified Beneficiaries (MQB)
- aged, blind, and disabled individuals who qualify under federal poverty income standards

Deductible Balance

All deductible amounts and deductible balances are determined by the county DSS by examination of medical bills or receipts provided by the recipient or from information furnished by providers.

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Medicaid Eligibility, continued

Verifying Eligibility

An adult recipient's eligibility status may change if their financial and/or household circumstances change. For this reason, providers should request Medicaid recipients to provide proof of eligibility each time a service is rendered. If a recipient states that a MID card has not been received in the mail, ask if a notice about a change in his eligibility status has been received, and the nature of the change. Medicaid policies require that recipients be given written notice in advance of any change in eligibility status.

Recipients who have both Medicare and Medicaid coverage should present their Medicare card, even if there is no indication of Medicare on their MID card. File claims with Medicare. Indicate XIX on a Part A claim so claims will be passed to Medicaid electronically; Part B carriers pass claims to Medicaid.

When other health insurance and Medicaid cover a recipient, the other health insurance is the primary payer and Medicaid is the payer of last resort. Health insurance, when known, is listed on a recipient's MID card. However, providers should ask all recipients at the time services are rendered for information on health insurance coverage or other third party liability.

The following methods may be used to verify current eligibility (i.e. eligibility for the current date and eleven prior months):

- Medicaid Identification Card
- Voice Inquiry System (for dates of service within 12 months of inquiry date)
- DMA Claims Analysis (for a MID number or dates of service over 12 months before date of inquiry)
- Electronic Data Interchange vendors (on-line verification)

See Appendix B for phone numbers.

Verifying Via The Medicaid Identification Card

A Medicaid Identification (MID) card with valid "FROM" and "THRU" dates covering the date(s) of service is proof of Medicaid eligibility. Providers should review the valid "FROM" and "THRU" dates on the card to ensure eligibility on the service date. A copy of a MID card showing eligibility on the service date guarantees payment of valid Medicaid claims, providing all guidelines have been met.

Verifying Via Voice Inquiry

Medicaid eligibility may also be verified through the Medicaid Voice Inquiry System, which allows enrolled providers to access detailed information regarding the North Carolina Medicaid Program, including recipient eligibility data. Eligibility verification is available for services provided on the date of the inquiry as well as for services up to one year old. Eligibility verification is not available for future services, since a recipient's eligibility status may change from month to month nor is verification available for services that are over a year old. See Appendix B for instructions.

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Medicaid Eligibility, continued

Electronic Data Interchange

Electronic Data Interchange (EDI) is an on-line, interactive eligibility verification program available via EDI vendors. These vendors interface with the Medicaid recipient database maintained by EDS for claims processing. Providers must contract directly with an EDI vendor for this service. See Appendix B for a telephone number to call for EDI information.

County Notification

The county DSS notifies recipients of eligibility approval, denial, or suspension by means of form notices. County notifications may be used to obtain recipient numbers and other information; however, ***they are not a guarantee of payment to the provider.***

The Medicaid Identification Card

Information on MID Card

Medicaid recipients receive a monthly MID card as proof of their eligibility, and the card shows the information necessary for filing claims. Since the recipient's eligibility may change from month to month, MID cards are replaced at the beginning of each month. The new card will show valid eligible dates only through the current calendar month. Each recipient has a unique MID number, although more than one recipient may be listed on a single MID card. The MID card shows the eligible dates for Medicaid as "FROM" and "THRU" dates printed on the card. Information on the back of the card instructs recipients and providers on the use of the card and provides information about prior approval.

Medicaid recipients should present a valid MID card at each provider visit. ***Recipients who fail to do so may be expected to pay for services received or may be refused service.***

County-Issued MID Cards

DSS may issue MID cards under these circumstances:

1. emergencies (when the original card is incorrect or has been lost or destroyed)
2. new applications
3. to provide retroactive eligibility dates

"EMERGENCY" is stamped on the top margin of the card of the county-issued card.

Counties have the option to detach the pharmacy stub from the card when replacing a lost card that was used for a portion of the month..

The Blue Medicaid Identification Card

Blue Medicaid Identification Card

The blue MID card indicates the recipient is eligible for all Medicaid-covered services. The card identifies the casehead of the family and additional eligible persons in the family. Each eligible family member has a unique recipient MID number. *Only those family members whose names and North Carolina MID card numbers appear on the card are eligible for Medicaid.*

For Carolina ACCESS members, the regular Medicaid card will indicate the name of the Carolina ACCESS primary care provider, the provider's address, and the daytime and after-hours telephone numbers. "Carolina ACCESS Enrollee" appears above the recipient address. The Carolina ACCESS physician whose name appears on the Medicaid card must be contacted to receive authorization for reimbursement. Each Carolina ACCESS enrollee in a family receives a separate MID card.

If the recipient is enrolled in Health Care Connection, "Prepaid Health Plan Enrollee" appears above the name of the recipient and the name, address, and phone number of the HMO will appear in the center of the card.

The following is an example of the blue Medicaid Identification Card:

The Pink Medicaid Identification Card

Pink Medicaid Identification Card

The pink MID card indicates the recipient is eligible only for pregnancy-related services. The name and identifying information of the pregnant women is shown, and no other eligible will appear on the card. A message is printed directly under the recipient name, MID number, etc., stating eligibility is limited to services related to pregnancy and conditions that may complicate the pregnancy. If a second message appears stating the recipient is presumptively eligible only, coverage is limited to ambulatory care.

The data fields used on the pink MID card are the same as those used on the blue card.

The following is an example of a pink Medicaid Identification Card:

Blue and Pink MID Cards–Explanation of Fields

The blue and pink MID Card fields are described in the following table:

Fields	Description
Month	Month and year the card is mailed
Case ID, Casehead	Return address of the county DSS, followed by an 8-digit case identification number and the name of the casehead.
Eligible Members	Eligible persons in the family, their unique Medicaid identification number. The card may list more than one eligible person in the family, or may list only one person.
CAP	Two alpha character code in the CAP field indicating person is authorized for home and community-based services in lieu of nursing facility care. CAP participants may be exempt from Medicaid copayment requirements.
County Case Number	Six-digit county case number. (If assistance is needed from the county DSS, the record can be located more quickly with this number.)
Issuance	Five-digit Julian date indicating date the card was prepared and mailed, followed by an "R" or "S" (regular or straggler mail runs).
Program	Three alpha characters designating the Aid/Program Category.
Class	One alpha character designating the case classification. ***This information is significant for providers who are limited to billing services for MQBQ or "Q" class recipients only.***
Valid From-Thru Dates	Indicates the dates of eligibility. The FROM date may show eligibility for prior months, in addition to the current calendar month. Future months of eligibility are never indicated since eligibility status may change.
Recipient ID	The Medicaid Identification (MID) is a 9-digit number followed by an alpha character.
Eligibles for Medicaid	The first name, middle initial and last name appear for each eligible recipient on the card. If the recipient is enrolled in **Carolina ACCESS**, the name and address of the Primary Care Provider, and his/her daytime and after-hours telephone numbers will appear below the recipient name. If the recipient is enrolled in **Health Care Connection**, the name, address, and telephone number of the HMO will appear below the recipient names(s).
Insurance Number	If a recipient is covered by one of the insurance resources shown in the Insurance Data block, the corresponding numbers will be shown here on a horizontal line. Example: If this block shows 1, 3, 4, the recipient is covered by the insurance resources shown on lines 1, 3, and 4 under Insurance Data Block. Match the type of coverage to see if third party filing with the appropriate insurance company is necessary. Refer to "Third Party Liability" on page 7-1 for additional information on insurance.

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Blue and Pink MID Cards–Explanation of Fields, continued

Blue and Pink Medicaid Identification Card Fields(continued)

Fields	Description
Birth date	The birth date for the corresponding recipient is listed by month, day and year.
Sex	For identification purposes.
Pregnancy-related services (Pink Card Only)	Message directly below the recipient MID number and name indicating eligibility for these services only.
Presumptive Eligibility Only Indicator (Pink Card Only)	A second message printed directly below the recipient MID number and name, limiting coverage to ambulatory care for pregnancy-related services.
Insurance Number	Lists specific third party insurance coverage data for eligible persons, including indicators for Medicare A and B.
Name Code	The insurance company's name appears here in a 3- digit code. DMA's Third Party Recovery Section supplies a code key book to all Medicaid providers. This book provides code keys to identify third party sources.
Policy Number	The insurance policy number consisting of alpha/numeric characters which may be up to 18 characters in length.
Type	A DMA 2-digit code indicating the type of coverage provided in the policy. The type of coverage codes are listed below: 00 - Major Medical Coverage 01 - Basic Hospital with Surgical Coverage 03 - Dental Coverage Only 02 - Basic Hospital Only Coverage 04 - Cancer Only Coverage 05 - Accident Only Coverage 06 - Indemnity Only Coverage 07 - Nursing Home Only Coverage 08 - Basic Medicare Supplement 09 - Medicaid HMO Contract 10 - Major Medical and Dental Coverage 11 - Major Medical and Nursing Home Coverage 12 - Intensive Care Only Coverage 13 - Hospital Outpatient Only Coverage 14 - Physician Only Coverage 15 - Heart Attack Only Coverage 16 - Prescription Drugs Only Coverage 17 - Vision Care Only Coverage
Casehead or Payee Name and Address	Generally the payee is the adult caretaker for eligible children or may be the same as one of the eligible persons listed on the card. The address is where the family receives mail.
Carolina ACCESS Enrollee	Message printed directly above the payee name and address.
Prepaid Health Plan Enrollee	Message printed directly above the payee name and address

The Buff Medicaid Identification Card

Buff MID Card

The buff MID card indicates the recipient is eligible for Medicaid payment of Medicare cost sharing charges only. If Medicare pays for the service, Medicare will automatically cross over Part B claims to Medicaid for payment of the coinsurance and/or the deductible. Part A claims cross over if the hospital indicates Medicaid coverage on the claim. If Medicare denies the service, Medicaid will also deny. Medicaid is the payer of last resort; therefore, private insurance and Medicare are billed first.

Note: Persons on a deductible for regular Medicaid may qualify for Medicare Qualified Beneficiary (MQB) during the deductible period. This would allow the individual to receive MQB coverage while waiting to meet the deductible for full Medicaid coverage.

The following is an example of the buff Medicaid Identification Card:

Buff MID Card – Explanation of Fields

The buff MID card fields are described in the following table:

Fields	Description
Program	Three-alpha characters designating the Aid/Program category
Issuance	Five-digit Julian date indicating date the card was prepared and mailed, followed by an "R" or "S" (regular or straggler mail runs).
Valid FROM-THRU dates	Indicates the eligibility period (month, day, year, from and thru) for which the MID card is eligible. Several months may be included in the eligibility period due to either retroactive eligibility or client's continued eligibility for a period of time with no change. The "THRU" date of coverage will be no later than the end of the current month.
Recipient ID	The Medicaid Identification number (MID) is made up of a 9-digit number followed by an alpha character.
Insurance Name Code	The insurance company's name appears as a 3-digit code. The Third Party Recovery Section at DMA will provide an Insurance Code book upon request.
Birth date	The recipient's birth date is listed by month, day, year.
Sex	"F" for female and "M" for male.
County Number	Indicates the recipient's county of responsibility.
Case Identification Number	The case number assigned to identify the recipient's Medicaid case. (This number is helpful when calling the county for assistance.)
County District Number	Indicates the district for county purpose only
Casehead Name and Address	This area indicates the recipient's name and address.

Recipient Responsibilities

Overview

When a recipient is issued a Medicaid identification card, he or she is responsible for:

- presenting a MID card for each Medicaid service
- informing the county of any status changes (in living arrangements, income, or other insurance)
- Medicaid-approved cost-sharing (copayments)
- applying for Medicare when appropriate

Presentation of MID Cards

The MID card is the recipient's proof that he or she is eligible for Medicaid during the dates specified on the card. If a recipient fails to present his or her MID card as proof of eligibility for Medicaid, the provider has the right to refuse service or to charge the recipient for the service.

Changes In Eligibility

A recipient has the responsibility to notify the county department of social services (DSS) of any changes in his or her eligibility status. Notice of a reduction in eligibility, such as a new deductible or termination of eligibility is always given in advance of the effective date, and recipients may appeal the proposed action.